

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395330	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/03/2025
NAME OF PROVIDER OR SUPPLIER Independence Rehab and Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 600 W Cheltenham Avenue Philadelphia, PA 19126	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0574 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The resident has the right to receive notices in a format and a language he or she understands. Based on observations, review of facility policy, and interview with residents and staff it was determined that the facility failed to ensure that residents were explained their resident rights for four of eleven residents reviewed. (R1, R76, R120, and R178). Findings Include: Review of the facility policy titled Resident Rights undated, reads Policy: The facility will inform the resident both orally and in writing, in a language that the resident understands, of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility will also provide the resident with prompt notice (if any) of changes in any State or Federal laws relating to resident rights or facility rules during the resident's stay in the facility. Receipt of any such information must be acknowledged in writing. Further review of the Resident Rights policy revealed, Policy Explanation and Compliance Guidelines: A posting of names, addresses and phone numbers of all pertinent state client advocacy groups will be available in the facility. During resident council group meeting held on September 17, 2025 there were five of eleven residents that stated they did not know what their resident rights were or how they would call the Department of Health to file a complaint. Review of resident council minutes from the months of April, May, June, July, and August, 2025 revealed there were no indication that any of the resident rights were reviewed during resident council. 28 Pa Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.29(d) Resident Rights		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on observations, facility policy review, and staff interview, it was determined that the facility failed to provide residents with the ability to file grievances anonymously for four out of four nursing units reviewed. Findings Include: Review of the facility policy titled, Grievance Policy dated November 2016 states, The facilities established grievance policy includes: Notifying the resident individually or through posting of the right to file grievances orally or in writing, the right to file grievances anonymously, the contact information of the grievance official, a reasonable expected time frame for completing review of the grievance, the right to obtain a written decision, the contact of independent entities to whom grievances may be filed (state agency, quality improvement or, state survey agency, state LTC ombudsman). Further review of the facility policy states, The facility Grievance Office is the Social Worker, and is responsible for: Overseeing the grievance process, receiving and tracking grievances to conclusion, leading any necessary investigations, maintaining the confidentiality of all information associated with grievances, issuing written grievance decisions, coordinating with state and federal agencies as necessary in light of specific allegations. Observations conducted of the First, Second, Third, and Fourth floor nursing units with the Social Services Director, Employee E16, on September 16, 2025 at 1:49 p.m. revealed that there were no grievance forms accessible to residents, caregivers, or family members to have the ability to form anonymous grievances. When Employee E16 was asked where grievance forms were, she stated, I have the forms in the office, the nurses have them in their office, but residents usually come to if they have a concern. Further observation of the grievance process in the facility revealed there were two grievance mailboxes where residents could turn in their grievance, but the boxes were not locked for privacy. Further observation during the tour revealed that it did not have any posting on the second, third or fourth floor in a prominent location about the right to file grievances in writing anonymously. The posting also did not include the reasons why you would file a grievance at the facility. Review of the facility grievance form provided revealed there was no space to indicate that the grievance was being formed anonymously. Further review of the grievance form revealed there was also no space to check off regarding the right to obtain a copy of the written decision regarding his or her grievance. 28 Pa. Code 201.18(b)(2) Management 28 Pa. Code 201.29(a)(i) Resident rights		

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notify the appropriate authorities when residents with MD or ID services has a significant change in condition. Based on review of facility documentation, and interview with staff it was determined that the facility did not notify the state mental health authority or state intellectual disability authority, promptly after a significant change in the mental condition for three of thirty-three residents reviewed. (R4, R53, R56). Findings Include: Review of Resident R4's psychiatry note from September 2, 2025 stated, [Resident R4] with noted history of schizoaffective disorder in electronic health records system and past psychology note. Resident R4 does not answer appropriately assessment questions and is a poor historian. [Resident R4] was previously prescribed Haldol, but medication was discontinued in 2024, after discontinuation, pt displayed no signs of psychosis. [Resident R4's] medical record includes no documentation confirming schizoaffective diagnosis. This patient does not meet DSM-5 criteria for schizoaffective please remove diagnosis. Continued review of the resident's record revealed no further communication with the state mental health authority. Review of Resident R53's psychiatry progress note from August 19, 2025 stated, attempted to evaluate to confirm Schizoaffective diagnosis due to limited background information being available in medical records. Resident does not answer appropriately assessment questions and is a poor historian, unable to give an accurate diagnostic history. Unable to locate history information in chart or medical records to confirm diagnosis. Resident does have a history of mood swings, anger and irritability per past evaluation. Discussed with RNAC (Registered Nurse Assessment Coordinator), will remove diagnosis. Continued review of the resident's record revealed no further communication with the state mental health authority. Review of Resident R56's progress note from September 2, 2025 stated, Resident seen today for a follow up visit related to previous Schizophrenia diagnosis. Resident received today in room, seated in wheelchair watching television. Resident currently denies feeling depressed or anxious. He denies history of Schizophrenia. The resident was admitted with a diagnosis of Schizophrenia but currently denies diagnosis, also denies ever utilizing psychotropic medications. This resident does not meet DSM-5 criteria for Schizophrenia, please remove diagnosis. Interview with the Director of Social Services Employee E19 on September 18, 2025 at 1:33 p.m. revealed the facility did have an audit and has been working on completing new PASSAR (Pre-admission Screening and Resident Review) forms and contacting the state mental health authority. 28 Pa Code 201.14 Responsibility of licensee		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of clinical record, review of facility policy and interview with staff, it was determined that the facility failed to ensure that a person-centered care plan was developed related to oxygen and PTSD (post-traumatic stress disorder) for two of 33 residents reviewed (Resident R11 and Resident R19) Review of facility's undated policy on Comprehensive Care Plan revealed that under section Policy: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. Section Policy Explanation and Compliance Guidelines:1. The care planning process will include an assessment of the resident's strengths and needs, and will incorporate the resident's personal and cultural preferences in developing goals of care. Services provided or arranged by the facility, as outlined by the comprehensive care plan, shall be culturally-competent and trauma-informed.2. The comprehensive care plan will be developed within 7 days after the completion of the comprehensive MDS assessment. All Care Assessment Areas (CAAs) triggered by the MDS will be considered in developing the plan of care. Other factors identified by the interdisciplinary team, or in accordance with the resident's preferences, will also be addressed in the plan of care. The facility's rationale for deciding whether to proceed with care planning will be evidenced in the clinical record.3. The comprehensive care plan will describe, at a minimum, the following:a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.g. Individualized interventions for trauma survivors that recognizes the interrelation between trauma and symptoms of trauma, as indicated. Trigger-specific interventions will be used to identify ways to decrease the resident's exposure to triggers which re-traumatize the resident, as well as identify ways to mitigate or decrease the effect of the trigger on the resident. Observation conducted on September 16, 2025, at 10:32 AM revealed that an oxygen concentrator was on Resident R11's bedside. Further observation revealed that the oxygen concentrator was not on. Interview with Resident R11 conducted at the time of the observation revealed that he only uses it at night for apnea. Review of Resident R11's clinical record revealed that Resident R11 was admitted to the facility on [DATE]. Further, Resident R11's diagnoses were but not limited to COPD (chronic obstructive pulmonary disease- a group of lung diseases that block airflow and make it difficult to breath). Review of physician's orders revealed an order for Apply oxygen (continuously) at 1liters/minute via NC (nasal canula) every shift for SUPPLEMENTAL -ordered 8.20.25 Review of Resident R11's Quarterly MDS (Minimum data set a federally required resident assessment completed at a specific interval) dated August 27, 2025, section O0110 (Special Treatments, Procedures, and Programs), C1. revealed that Oxygen therapy was coded yes. Further review of Resident R11's clinical record revealed that no person-centered care plan for oxygen was developed and implemented. Review of Resident R19's clinical record revealed the residents diagnoses of diagnosis of Post Traumatic Stress Disorder (PTSD- a mental condition that can developed after experiencing and/or witnessing a traumatic event)).Review of Resident R19's Quarterly MDS dated [DATE], section I0020 revealed that Resident R19 had a diagnosis of Post Traumatic Stress Disorder (PTSD).Review of Resident R19's care plan revealed that no person-centered care plan for PTSD was not developed and implemented. 28 Pa. Code 211.10(c) Resident care policies 28 Pa. Code 211.12(d)(1) Nursing service		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical record, review of facility policy and interview with staff, it was determined that the facility failed to provide timely pressure ulcer treatment for one of nine residents reviewed (Resident R13). Review of Resident R13's clinical record revealed that Resident R13 was admitted to the facility on [DATE], with diagnoses of but not limited to Hypertension (high blood pressure), Rheumatoid Arthritis (isa chronic autoimmune disease that primarily affects the joints), Hypothyroidism (condition due to deficiency in the thyroid hormone resulting in decreased body metabolism).Review of Resident R13's MDS (minimum data set a federally required resident assessment completed at a specific interval) dated June 26, 2025, revealed that section GG0130. Self-Care C. Toileting hygiene: was coded has dependantant.Review of nurse's aide task revealed that for toileting and hygiene Resident R13 was dependent to maximum assist.Review of Resident R13's nursing note dated July 25, 2025, reveal that Nurse's Aide reported that resident complained of pain on her right heel. On assessment resident observed with deep tissue injury to right heel. Skin prep applied, message left for MD (physican).Review of Resident R13's skin assessment dated [DATE], performed by a licensed nurse revealed that resident was at risk for skin breakdown. Further section G (Additional observation) of Resident R13's skin assessment revealed a note that Resident R13 had DTI (deep tissue injury) to left heel and had a right buttocks skin alteration.Review of July 2025 physician's order revealed an order to Cleanse Right buttock with NSS (normal saline solution) apply Adaptec and cover with clean drydressingevery evening shift for skin alteration -Start Date-07/27/2025 -D/C (discontinued) Date-07/28/2025-Santyl Ointment 250 UNIT/GM (Collagenase)Apply to per additional directions topically every evening shift for wound care -Start Date-07/28/2025 -D/C Date-08/10/2025-Cleanse Right buttock with NSS apply Santyl calcium alginate cover with clean dry dressing. every evening shift for skin alteration-Start Date-07/29/2025-D/C Date-09/13/2025 Further review of Resident R13's clinical record revealed no documented evidence that the physician and addressed the DTI to left heel and right buttocks skin alteration which were identified on July 25, 2025, until July 27, 2025, and wound treatment was not started until July 27, 2025. 28 Pa. Code 211.10(c) Resident care policies 28 Pa. Code 211.12 (c)(d)(1)(3)(5) Nursing Services.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observations, review of facility documentation, and staff interviews, it was determined that the facility failed to ensure that hot beverages were served at a safe temperature during a resident activity in one of four floors. (Second floor dining room) Findings include: The FDA, Consumer Product Safety Commission, and the American Burn Association all warn against serving beverages at temperatures above 150 F, as liquids at or above this level can cause severe burns within seconds. According to these organizations, a serious burn can occur in just one second when a beverage is served at 160 F. To minimize the risk of scalding injuries, best practices recommend that hot beverages be served at temperatures between 130 F and 160 F. Review of The American Burn Association https://ameriburn.org, revealed at 140 degrees Fahrenheit, serious burns can occur in about five seconds and a 160 degrees Fahrenheit it can happen in just one second, this underscores how quickly severe burns can occur from hot liquids. Observation on n September 15, 2025, at approximately 11:00 AM, during a scheduled coffee hour in the second-floor dining and activity room, approximately 20 residents were observed consuming coffee served in paper cups with lids. Activity assistant Employee E10, was observed pouring and distributing the coffee. During preparation, steam was visibly rising from the cups, indicating that the beverage was very hot. When a surveyor requested a cup and sampled the coffee, it was found to be hot. Upon being asked about the beverage temperature, Employee E10 stated they did not know the temperature. The employee then left the activity room to find a kitchen staff member to assist in measuring it. Observation of kitchen staff, Employee E26 on September 15, 2025, at approximately 11:20 AM, revealed that Employee E14 entered the room and used a thermometer to check the coffee temperature, which registered at 167 F. When asked about the acceptable temperature range for serving hot beverages, Employee E14 was unable to provide a definitive answer and guessed that around 160 F was appropriate. Interview with Dietary Supervisor, Employee E7 on September 15, 2025, at 11:35 a.m., in the kitchen the Dietary Supervisor, employee E7 explained that it is not the kitchen's responsibility to monitor beverage temperatures for activities. Instead, she stated that the activity staff are expected to ensure the beverages are served at a safe temperature. When asked to provide a written temperature policy for hot liquids, Employee E7 was unable to do so. She indicated that there was no formal policy in place and noted that kitchen staff generally believe that 160 F is an acceptable serving temperature. Further observation in the kitchen at approximately 11:50 AM revealed coffee being poured for lunch tray distribution. A thermometer reading showed the coffee temperature at 170 F and the hot water temperature at 185 F. A review of the kitchen's temperature logbook for the month of September indicated that, on multiple days, coffee temperatures were not recorded. Notably, on September 12, 2025 the coffee was documented as having left the kitchen at a temperature of 180 F. On September 16, 2025, at 2:50 PM, an interview was conducted with the Nursing Home Administrator, Employee E1. During the interview, the administrator confirmed that the facility does not have a written policy outlining the acceptable temperature range for serving hot liquids. Employee E1 acknowledged the potential safety risk this poses to residents and recognized that serving improperly monitored hot beverages could result in serious burns. 28 Pa. Code 201.18 (b)(1) Management 28 Pa. Code 201.20 (a)(1) Staff development		

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. Based on clinical record review and staff interview, the facility did not ensure that nurse aides received annual performance evaluations to assess competency and performance, as required. Findings Include: An interview was held on September 17, 2025 at 2:45 p.m. with Employee E1 the Nursing Home Administrator. Employee E1 when asked to provide evidence nurse aides were evaluated at least every 12 months. Employee E1 stated, we don't have any nurse aide evaluations. I thought that they needed the required trainings only. Based on the information above, the facility could not provide any nurse aide evaluations during the past 12 months. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 211.12(c) Nursing services		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, review of facility documentation and staff interview, it was determined that the facility failed to ensure that dietary equipment to maintain hot foods remain in functional capacity. Findings include: Observations of the food and nutrition services department on September 15, 2025 at 11:30 a.m., in the presence of the food service director, Employee E7, revealed that the plate warmer was not equipped with a lid/cover that was necessary to contain heat. This piece of foodservice equipment was designed to warm/heat the ceramic plates that were used for plating and serving meals to the residents. The ceramic plates were not hot to touch. Additional observations of the food and nutrition services department on September 15, 2025, revealed that the dietary operation was not using a complete thermal system for maintaining hot foods (meals) during transportation and delivery to the nursing units from the main kitchen. Interview with the Director of Dietary Services at 11:30 a.m., on September 15, 2025, revealed that the thermal pellet base charger and thermal pellet base under liners had been non-functional for several months and that a request had been placed by the food and nutrition services department for administration to purchase new equipment (thermal pellet base charger and thermal pellet base under liners). A review of the undated facility policy titled resident tray assessment revealed that the service temperature standards for the hot entree, starch and vegetables at mealtimes, for the residents were established at 130 degrees Fahrenheit. A review of the food committee meeting minutes dated May 21, 2025, revealed that the residents were voicing concerns about the palatability and temperature of the foods being served to them, from the dietary services department. The residents were reporting that foods were unappetizing and not served at proper temperatures. A review of the food committee meeting minutes dated August 13, 2025, revealed that the residents were complaining that the hot foods from the main kitchen were being served cold. Observations of the meal delivery for the residents on the second-floor nursing unit, during the noon meal on September 16, 2025, confirmed that the temperature of the hot foods were not appetizing at point of service for the residents. Foods evaluated were the beef soft tacos sauteed peppers and onions and Mexican corn. The hot food entree, starch and vegetables tested at 109 degrees Fahrenheit. 28 Pa. Code 201.14(a) Responsibility of licensee		

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, interviews with staff and reviews of policies and procedures, it was determined that the Nursing Home Administrator and Director of Nursing effectively and efficiently implemented resources to management incidents of resident abuse and failed to ensure that behavior management resources were implemented for one of seven sampled residents (Residents R148) Findings include:A review of the facility policy titled accident and incident-investigation, and reporting dated July 2017 revealed that all accidents and incidents involving residents occurring on the premises were to be investigated and reported to administration. The nursing supervisor was required to document and investigate the accident and incident. The report was to contain the circumstances surrounding the accident and incident, names of all parties involved such as witnesses and their accounts of the accident or incident, residents' statements of the event, the physician's response to the event was to be documented, vital signs and nursing measures instituted, any corrective action taken to prevent the accident or incident in the future and any follow-up action to prevent and accident and incident from happening again. The documented accident and incident report was to be submitted to the director of nursing and the administrator. The director of nursing and the administrator were responsible for reviewing the accident and incident for safety hazards and individual resident vulnerabilities to ensure the residents' environment was safe. Review of Resident R148's MDS quarterly assessment (MDS-an assessment of care needs) dated July 23, 2025, indicated this resident had adequate vision and hearing. The resident was assessed with disorganized thinking (rambling, irrelevant conversation, unclear ideas, unpredictable switching from subject to subject). Continued review of the MDS revealed the resident was independent with functional abilities and activities of daily living that included ambulation. The assessment indicated that this resident had diagnoses of anxiety disorder, depression and schizophrenia (disease characterized by loss of reality contact). Review of Resident R101 MDS quarterly assessment dated [DATE], revealed that the resident was able to express ideas and wants and understood verbal content. Review of nurse practitioner's notes dated April 4, 2025, indicated that Resident R101 was awake alert and oriented. Review of psychiatrist notes dated March 24, 2025, indicated that Resident R101 was alert and oriented. Review for Resident R148 revealed that the resident left the first-floor nursing unit ambulating without supervision at 6:00 a.m., on April 6, 2025. On April 6, 2025, the nursing staff documented that Resident R148 was found in room [ROOM NUMBER] standing over Resident R101 while the resident was sleeping. A nursing staff member reported that Resident R148 was shaking resident R101 to wake him up. Interview with Resident R101 at 11:00 a.m., on September 18, 2025, revealed that Resident R148 was trying to grab his private area, when he entered his room on April 6, 2025. The clinical record indicated that as the nurse went over to Resident R148 to stop him from shaking Resident R101, Resident R148 turned and spit on the nurse then with a closed fist punched the same nurse in the face. The nursing staff documented that Resident R148 continued to wander away from the first-floor nursing unit. The nurse also documented that the resident was unable to be redirected. There was no statement available for review from Resident R101, who was cognitively intact and able to make his needs known to staff. Interview with the director of nursing and the administrator at 10:00 a.m., on September 17, 2025, confirmed no safety measures were instituted to protect Resident R101 after incident on April 6, 2025.Review of Resident R76 revealed an admission MDS comprehensive assessment dated [DATE], that indicated this resident was cognitively intact. The assessment also indicated that this resident had no upper or lower body functional limitations with range of motion. Resident R76 was assessed as able to ambulate ten feet with supervision and that no assistive device needed for walking. Review of Resident R148 revealed an incident on August 8, 2025, that indicated this resident walked into the rehabilitation gym on the first floor of the facility and without being provoked began screaming, cursing and lunging at Resident R76. Resident (continued on next page)		

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R148 told Resident R76 that he was going to kill him. Interview with Resident R76 at 1:00 p.m., on September 17, 2025, revealed that he thinks Resident R148 should be closely monitored and not walking freely throughout the entire facility. Resident R76 said that he was capable of defending himself; however, some other residents that live here were not as physically able and were more vulnerable to his verbal threats and aggressive behaviors. There was no documented accident or incident report available for review for the incident that took place in a common area of the facility with staff working on August 8, 2025, between Resident R148 and Resident R76. There were witness statements recorded (staff or residents). There was no documentation to indicate what the preventative action or corrective action taken by the facility to prevent further occurrences of verbal threats and aggressive behaviors by Resident R148 with Resident R76 and other residents living at this facility. Interview with the Director of Nursing Home Administrator at 1:15 p.m., on September 17, 2025, confirmed the lack of documented investigation and preventative measures following the incident that took place on August 8, 2025, between Resident R148, the aggressor and Resident R76 the victim. Clinical record review revealed that Resident R148 was exhibiting aggressive, combative and sexually inappropriate behavior on August 29, 2025, on the first-floor nursing unit. Resident R148 was observed with his pants lowered engaging in inappropriate self-stimulation while rubbing his genital area as he watched the nursing staff at the medication cart in the hallway. Upon redirection the resident became agitated, raising his voice and displaying combative gestures. Interview with the Director of Nursing and the Nursing Home Administrator at 1:20 p.m., on September 17, 2025, confirmed the lack of documentation and investigation related to the above mentioned incident that took place on August 29, 2025. Clinical record review for September 11, 2025, revealed that Resident R148 was pacing the hallways and lobby of the facility located on the first floor of the building all during the night. The nursing staff indicated that on September 11, 2025, Resident R148 was observed blowing smoke in the face of a nurse staff member. The nursing staff member also noted that resident R148 was using profane and racially derogatory language toward the nursing staff. Interview with the Director of Nursing and the Nursing Home Administrator at 1:30 p.m., on September 17, 2025, revealed that there was no documented accident and incident report for the incidents documented by the nursing staff on September 11, 2025. The administrator reported being unaware of Resident R148 having smoking materials inside the facility. The administrator reported that Resident R148 does leave the facility with his brother at times, during approved leaves. The administrator reported that smoking or vaping was not allowed in the building. The Director of Nursing and Nursing Home Administrator reported that there were no corrective actions or follow-up actions to prevent the following incidents that occurred on September 11, 2025, involving Resident R148. Clinical record review on September 12, 2025, for Resident R148 revealed that this resident came out of his room naked, went to the residents' dining area and began masturbating all over the place. The nursing staff documented that Resident R148 was not able to be redirected. Interview with the Director of Nursing and the Nursing Home Administrator at 1:45 p.m., on September 17, 2025, revealed that there was no documented accident or incident report, in accordance with the facility's policies for the incident that took place on September 12, 2025, for Resident R148. The Director of Nursing and Nursing Home Administrator were unaware if there were other residents in the dining/activities area during Resident R148's demonstration of inappropriate sexual behavior. The Director of Nursing and Nursing Home Administrator reported that there were no corrective actions or follow-up care planning measures documented for the sexually inappropriate behavior that occurred on September 12, 2025, involving Resident R148; because they were unaware that this incident had happened or the surrounding circumstances that took place. Refer to R740 Refer to F610 28 PA. Code 201.14(a) Responsibility of licensee 28 PA. Code 201.18(b)(1) Management 28 PA. Code 211.10(c)(d) Resident care policies 28 PA. Code 211.12(d)(1)(5) Nursing services		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395330	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/03/2025
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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, facility policy review, and staff interviews, the facility failed to develop and maintain an accurate, comprehensive facility-wide assessment. Findings include: Review of the facility's policy titled Facility Assessment (dated 2025) revealed that the facility is required to complete and document a comprehensive facility-wide assessment to determine the resources necessary to care for residents competently during both routine operations and emergencies. The policy identifies that the facility assessment must include, at a minimum:- The resident population, including number, facility capacity, and care needs using data-driven methods that reflect disease types, physical and behavioral health needs, cognitive impairments, and acuity levels;- Physical environment, equipment, services, and cultural/religious factors that may affect care.- Facility resources including staffing, equipment, therapy, pharmacy, behavioral health services, and all contracted services.- Responsibility for completion assigned to the Administrator; and- Annual updates or as necessary. Review of the facility's most recent Facility assessment dated [DATE], and reviewed by the QAPI (Quality Assessment Improvement Plan) Committee on July 30, 2024, revealed that the document was outdated and lacked several required components:- The description of the resident population was incomplete. Disease types and acuity levels were not accurately listed. Psychiatric and mood disorders were addressed only through third-party contracts with no analysis of prevalence or impact on care delivery.- Under intellectual disabilities and other complex needs, vague statements were provided, such as follow-up with specialists or as directed by Medical Director, without defining specific staff competencies or resources.- The evaluation of staff competencies was absent. The document stated only that staffing meets or exceeds minimum ratios, without analysis of specific training or skill sets required to meet the care needs of the resident population.- The resource and service evaluation lacked detail. Statements such as CNA staff assist with ADLs, behavioral health monitored through documentation, and infection control monitored by program were too general and did not demonstrate an analysis of resources necessary to meet actual resident needs. Interview with the Nursing Home Administrator (NHA) on September 18, 2025 at approximately 10:00 a.m. revealed that he considered the assessment to be complete. During a follow-up interview on 9/19/2025 at approximately 9:00 a.m. the NHA acknowledged that the original Facility Assessment was missing required information and confirmed that a revised assessment had been created after surveyor inquiry. The updated document included more detailed information that had previously been omitted. The NHA confirmed that the added content was completed only after the initial surveyor interview. 28 Pa. Code (a)(j) Responsibility of Licensee		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident and staff interviews, and review of facility policies, it was determined that the facility failed to ensure that residents are treated with dignity and respect for one of 35 residents reviewed. (Resident R183) Findings include: Review of Resident R 183's quarterly Minimum Data Set (MDS-a federally mandated assessment tool for all residents) dated September 4, 2025, revealed that Resident R183 was admitted to the facility on [DATE], with diagnoses of hypertension (high blood pressure), asthma (condition that causes the airways to swell, narrow and fill with mucus), and bipolar disorder (mental condition that causes extreme mood swings). The residents' cognitive status, as measured by the Brief Interview for Mental Status (BIMS), yielded a score of 10, indicating moderate cognitive impairment. Observation on September 16, 2025, at 08:30 a.m. on the second-floor nursing unit revealed Licensed Nurse, Employee E12 administering medications to Resident R183. Licensed nurse, Employee E12 asked the resident to remove her bracelets, stating she could not take her blood pressure otherwise, Resident R183 refused. The nurse responded by stating she could not reach the resident's upper arm and asked her to move. The resident verbally expressed dissatisfaction, saying, Stop flipping your hair and rolling your eyes at me. The nurse later returned with the medication and stated, Here you go, [NAME], I got your meds. The resident became visibly agitated and responded, Don't call me ?[NAME]. My name is xxxx The nurse then exited the room without further communication. Interview with Resident R183 at time of the observation revealed that this resident felt disrespected by the nurses demeanor, including flipping her hair and rolling her eyes, and using patronizing language ([NAME]). She reported that she did not appreciate the attitude and stated, I will not take that from nurses. Interview with Licensed nurse, Employee E12, following the above interaction, confirmed that the interaction and described the resident as difficult. 28 Pa. Code 211.12 (d)(1) Nursing Services		

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of clinical records, staff interview, and review of facility policies, it was determined that the facility failed to ensure that one of 33 residents reviewed was assessed to self-administered medications. (Resident R77) Findings Include: Review of the facility's policy titled Medication Self-Administration revealed that residents are not permitted to retain or self-administer medications in their rooms unless the primary physician writes an order authorizing self-administration and the interdisciplinary team determines the resident is capable of doing so safely. An evaluation of the resident's ability to self-administer must be conducted and documented. The physician's order must be signed and dated prior to self-administration. Self-administration must be reflected in the resident's care plan and reviewed at least quarterly or upon any clinical change in the resident's status. Review of Resident R 77's Minimum Data Set (MDS- a federal mandated assessment tool for all residents) dated June 20, 2025, revealed the resident was admitted on [DATE], with the diagnoses of hypertension (high blood pressure), diabetes (the body cannot regulate glucose), cerebrovascular accident (CVA-stroke), seizure disorder (uncontrolled jerking, loss of consciousness, blank stare caused by abnormal electrical activity in the brain), and asthma (chronic condition that effects the airways in the lungs, causing wheezing, shortness of breath and coughing). The resident's Brief Interview for Mental Status (BIMS) score was 15, indicating intact cognition. Review of Resident R77's care plan dated June 20, 2025, revealed that the resident is care planned for behaviors including resisting care, combativeness, hoarding, and frequent refusal of lab work, ACCU (blood sugar) checks, and medications. There is no indication that this resident is able to self-administer medications. Observation on September 16, 2025, at 12:30 PM revealed two medication inhalers on the resident's bedside table. Licensed nurse Employee E 25 removed the inhalers from the resident's possession. Interview with the resident at time of the observation confirmed the inhalers were hers and that she self-administers them. Interview with licensed nurse Employee E25 at time of the observation confirmed the inhalers were on the bedside table and stated that the resident does not allow nurses to administer them. Licensed nurse employee E25 further stated she was unaware of any physician's order for self-administration, saying, I guess not. 28 Pa. Code 211.10 (c) Resident care policies 28 Pa. Code 211.12(d)(1) Nursing Services		

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observation, review of facility policy and interview with residents and staff, it was determined that the facility failed to ensure to maintain privacy for resident's clinical records during medication administration and incontinence care for two of thirty-one residents observed (Resident R168 and R207). Findings include: Review of undated facility policy title HIPAA Security Measures revealed that under section Policy: It is the facility's policy to implement reasonable and appropriate measures to protect and maintain the confidentiality integrity and availability of resident's identifiable information and or records that are in electronic format. Under section Policy Explanation and Compliance Guidance #1. Facility leadership will ensure the implementation of policies and procedures to prevent detect contain and correct any security violations. #3. Only appropriate employees will have access to electronic protected health information. #8. Physical safeguards will be implemented that limit physical access to its electronic information systems and the facility of facilities in which their housed, while insuring their properly authorized access is allowed. Observation of the fourth floor East Side Medication Cart conducted on September 16, 2025, at 11:18AM revealed that the medication cart was parked against the wall outside the medication room unattended. Further, the laptop on top of the medication cart was open. Further observation revealed that Resident R207's clinical information was visible to passersby. Review of the facility policy titled, Promoting/Maintaining Resident Dignity undated states, policy-It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment, that maintains or enhances resident's quality of life by recognizing each resident's individuality. Continued review of the procedure revealed. 12. Maintain resident privacy. On September 15, 2025 at 10:53 a.m. an interview was held with Resident R168. Resident R168 talked about how he has made complaints about his roommates being changed while he is in the room and not pulling the curtain and nothing it ever done. A re-visit was completed for Resident R168 on September 15, 2025, at 1:28p.m. and all the residents in the room had just been served their lunch in their room. Observation while exiting Resident R168 room revealed nurse aide Employee E16 going to pull closed Resident R168 curtain and one other roommate's curtain. Observation while outside of Resident R168 room after exiting the room revealed Employee E16 going to change Resident R168's roommate and Employee E16 did not pull the roommates curtain closed. Employee E16 stated, Keep your curtain closed like that Resident R168 and you won't see anything. Interview with Unit clerk, Employee E26 conducted at the time of observation confirmed that the laptop was opened. Further Employee E26 went to look for the nurse who was in-charge of the cart. Follow-up interview with Unit Manager Employee E27 conducted on September 17, 2025, at 11:43AM confirmed that the medication nurse, Employee E28 left the laptop open and unattended on September 16, 2025. 28 Pa. Code 201. 211.5 Medical records		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of clinical records and staff interview, it was determined that the facility failed to maintain a safe, clean, and comfortable environment in a manner that promotes a homelike atmosphere for residents for one of 33 residents reviewed (Resident R1 and Resident R62) and on one of four nursing floors. (Third floor) Findings Include: Review of facility policy titled, Resident Rights undated states that the resident has the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. Further review of the policy states that residents have the right to a 8. Safe environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Observations conducted during a tour of the Third Floor on September 15, 2025 at 9:40 a.m. revealed the following: At 10:01 a.m. the Third-floor high side had foul odors of urine and feces. At 10:53 a.m. room [ROOM NUMBER] was observed with a ceiling tile by the window that had two broken corner pieces. The resident's closet doors had a lot of dirt build up. At 10:58 a.m. room [ROOM NUMBER] was observed with several towels that appeared to have been saturated and since have dried. Interview with the Director of Maintenance At 1:07 p.m. room [ROOM NUMBER] was observed with two stained ceiling tiles and the over the bed light for bed B flickering. The third-floor pantry area also had food particles and paper trash between the cabinets and the refrigerator. Observations of Resident R62 at 11:30 a.m., on September 15, 2025, revealed that this resident was in bed looking out the window. Clinical record review for the speech therapy department revealed an assessment dated [DATE], that indicated that this resident had a diagnosis of cerebral vascular accident (stroke) and difficulty communicating. The speech therapist indicated that if questions are phrased for a yes/no response that Resident R62 was able to respond appropriately. Observations of Resident R62's room revealed that her roommate had a television, and it was angled toward the roommate so that she could visualize it. Resident R62 was asked if she could see the only television in the room. The resident shook her head no. Observations of Resident R62's bedroom revealed that this resident had no personal effects or memories as decoration. The recreational therapist reported that Resident R62 had no family visiting or contacting her that the facility staff were aware of. The recreational therapist reported that she would also look into Hispanic music for Resident R62, since this resident was of Hispanic origin. Observations of Resident R1 revealed that this resident was in bed in her room during all days of the survey (September 15 through September 19, 2025). There were no personal effects (pictures of family, places or things) that this resident enjoyed in her room. Clinical record review revealed a psychiatrist progress note dated August 18, 2025, that indicated this resident was awake and alert with fair concentration, judgement and memory. The nursing note dated July 14, 2025, indicated that Resident R1 was alert and oriented. The activities assessment dated [DATE], indicated that it was important for Resident R1 to take care of her personal belongings. The resident was also reporting that it was important to her to have her family involved in her care. The resident said that religious services and her favorite activities were things she wanted to do while living at the facility. Interview with Resident R1 and the licensed nurse, Employee E27, at 10:30 a.m., on September 16, 2025, revealed that the resident would like her daughter, who was her responsible party, to bring in some pictures of the family for her to have in her room as decoration and fond memories. The licensed practical nurse, Employee E27 also said that she was ask Resident R1's daughter for any religious statues or bible for her mother to use for reading and prayer. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa Code 201.14 (a) Responsibility of licensee.		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations of care and services, reviews of facility policies and procedures, interview with residents and staff, reviews of facility documentation and clinical records, it was determined that the facility failed to ensure that allegations of verbal abuse, mental abuse and physical abuse were reported promptly and thoroughly investigated for three of thirty-one residents reviewed. (Resident R2, Resident R148, Resident R211 and Resident R45) Findings include: A review of the undated policy titled abuse, neglect and exploitation revealed that it was the responsibility of the facility to provide protection for each resident to prohibit and prevent abuse, neglect, exploitation and misappropriation of property. The policy indicated that alleged allegations of abuse (psychological, neglect for the provision of safe care for residents, verbal abuse, misappropriation of property and sudden changes in behaviors such as fear of a person) would be thoroughly investigated immediately. All alleged violations of abuse would be reported to the administrator, state agency, adult protective services and all other required agencies (law enforcement) within specific time frames. An immediate investigation into the possible or alleged abuse would be conducted by the staff responsible for the investigation. The investigation was to include identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses and others. The focus of the investigation was to determine if abuse occurred, to what extent and the cause of the possible abuse. The facility policy indicated that a complete and thorough documentation of the investigation was to be kept on file. A review of the policy titled accident and incidents investigating and reporting dated July 2017 revealed that it was the responsibility of the administrator to ensure that all accidents and incidents involving residents occurring on the premises be investigated and reported. The policy said that the nurse supervisor was responsible to promptly initiate and document the investigation of the incident or accident involving the resident(s). The incident and accident investigation was to include circumstances surrounding the event, names of witnesses and their accounts of the event, the injured persons account of event, response by the attending physician to the event, the condition of the injured person including vital signs, any corrective action taken to prevent the incident from reoccurring and other pertinent data as required. Review of Resident R45's quarterly Minimum Data Set (MDS-an assessment of care needs) dated March 4, 2025, indicated this resident was cognitively impaired. This assessment revealed that this resident had no problems with vision or hearing. The assessment also indicated that Resident R45 required staff assistance to roll side to side, moderate assistance of staff for transfers from bed to chair and chair to bed. Resident R45 had a diagnosis of aphasia (difficulty communicating), cerebral vascular accident (stroke) and anxiety disorder. Review of Resident R148's annual comprehensive MDS dated [DATE], revealed that this resident was confused with disorganized thinking. This resident had no functional upper and lower extremity impairments. Resident R148 was documented as independent with all activities of daily living including ambulation. Review of a psychiatrist note dated July 1, 2025, indicated Resident R148 had a diagnosis of schizophrenia (disease characterized by loss of reality contact) and on-going behavioral health issues of aggressive and threatening behavior toward others, masturbation in public areas, screaming and yelling throughout the day that was anxiety provoking for the other residents. Clinical record review revealed a nursing note dated February 22, 2025, that indicated a nursing assistant, Employee E30, observed Resident R148 proceed to get on top of Resident R45, while Resident R45 was supine in bed. The licensed nurse, Employee E29, noted that Resident R45 had a frightened look on his face about Resident R148 attempting to get on top of him. Clinical record review revealed a psychiatrist evaluation dated March 3, 2025, that indicated Resident R148 made an effort to get on top of Resident R45. Resident R45 was in bed in a supine position. The psychiatrist documented that Resident R45 was fearful and confused because of Resident R148's behavior of trying to get on top of him, while he was lying on his back in bed. Interview with Registered nurse, Employee E28, at 10:00 (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a.m., on September 18, 2025, revealed that she was working on the seven to three shift during the occurrence of the incident on February 22, 2025; where Resident R148 proceeded to get on top of Resident R45. Registered nurse, Employee E28 reported that although she was working when the incident happened; she was not asked to give a statement related to the circumstances of the event. Employee E28 reported that Resident R45 was afraid and fearful of Resident R148. Registered nurse, Employee E28 stated that Resident R45 was not capable of physically defending himself or speaking to staff about Resident R148, since he had a diagnosis of dysphagia (difficulty swallowing). Registered nurse, Employee E28, reported that her assessment of Resident R45 on February 22, 2025, was that this resident was scared and fearful of Resident R148. Employee E28 reported that a room change for Resident R45 took place after the incident with the roommate Resident R148, so that Resident R45 was not a victim of sexually inappropriate behavior or physical injury by the roommate Resident R148. The registered nurse, Employee E28 confirmed at 10:15 a.m., on September 18, 2025 that the nursing assistant, Employee E30, found Resident R148 climbing into bed with Resident R45. The licensed nurse, Employee E29 documented on February 22, that when she asked Resident R148 why he was getting into bed with Resident R45, he replied Leave me alone! Get out of my face!"The possible emotional or psychological abuse of Resident R45 by Resident R148 was not reported to the State Survey Agency as required. Written statements were not taken from all staff responsible for the care of these residents on February 22, 2025. Resident statements were not recorded about the possible emotional or psychological abuse exhibited by the aggressor, Resident R148 on February 22, 2025. Review for Resident R211's quarterly MDS assessment dated [DATE], indicated that this resident had no functional limitations with upper or lower extremity range of motion. The assessment also indicated that this resident was independent with ambulation and transfers bed to chair/ chair to bed. The assessment indicated that Resident R211 was alert and oriented with diagnoses of seizure disorder and attention deficit hyperactivity disorder. Review of Resident R148's annual comprehensive MDS dated [DATE], that indicated this resident had no functional impairments of the upper or lower extremities. The assessment indicated that the resident was independent with activity of daily living, including ambulation. The assessment said that this resident had a diagnosis of anxiety disorder, depression and schizophrenia (mental disease of the brain characterized by lost of reality).Review of nursing documentation revealed that on May 18, 2025, Resident R148 was found in a physical altercation with Resident R211. The residents were in the hallway, and the nursing assistant was yelling, no wait, don't do that. Resident R148 was seen using his hand and forcefully hitting Resident R211 in his face multiple times. The licensed nurse documented that she observed Resident R211 fall to the floor; after being punched and during the fall the resident hit his head on the handrailing wall. The licensed nurse assessed Resident R211 post fall and on May 18, 2025. The licensed nurse documented that she gave advice to Resident R211 post fall with hitting his head on May 18, 2025. The licensed nurse's recommendation to Resident R211 was that he would consent to be evaluated further at the hospital. The nurse documented that the resident refused to go to the hospital. The possible physical abuse for Resident R211 was not completely investigated and reported to the State Survey Agency as required. Written statements were not available for review from residents living on the west wing (A, B, C) nursing unit where the incident on May 18, 2025, took place. The administrative staff failed to determine the causative factor of the incident that occurred on May 18, 2025 and put care plan measures in place to prevent further occurrences of physical aggression and injury for Resident R211. Clinical record review revealed a psychiatrist progress note on May 19, 2025, that indicated Resident R211 reported that he does not like the way Resident R148 speaks to the nurse. Interview with the registered nurse, Employee E28, at 11:00 a.m., on September 18, 2025, revealed that Resident R148 speaks disrespectful to the nursing staff frequently. The registered nurse also said that Resident R148 makes derogatory sexual comments to the nursing staff as well. Interview held with Resident R2 after holding resident council on September 17, 2025 at 10:49 p.m. The resident want to talk privately about a resident (R148) that on Monday night September 15 (continued on next page)		

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Form Approved OMB
No. 0938-0391

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	she had been verbally attacked and threatened by Resident R148. Resident R2 stated that on Monday, he threatened me saying, B****, m***** f*****, I'll punch you in your face, I'm going to kick your a**, if I catch you on the first floor I will punch you in the face. Resident R2 stated that this happened on the first floor by the lunchroom. When asked if anyone else witnessed what happened she stated the man who handles the money came out. Resident R2 reported that she filled out a grievance with a male staff, but when she asked for a copy of the grievance she got upset because he did not write everything down that she stated. She stated that since then no one has come to talk with her. Interview held with Employee E18 who stated he was the nursing supervisor on shift from 3 p.m.-11p.m. shift on September 15, 2025. Employee E18 stated that Resident R2 did come to him and complained something about Resident R148. When asked about specifics, he stated he could not remember. When shown the incomplete grievance form, Employee E18 stated that was the grievance form he filled out for Resident R2. When asked where he got the grievance form, he stated from my office. When asked where he took the form after filling it out, Employee E18 stated he slid it under the social service office door. On September 17, 2025 at 2:33 p.m. an interview was held with the Director of Social Services Employee E19 was interviewed and stated there was no grievance form found or submitted on or after September 15, 2025 for Resident R1. When asked where the original grievance form was, Employee E19 stated, we don't know, we do have a copy of the grievance form from Resident R1 and nursing is completing the form and starting the investigation now. On September 17, 2025 at 3:10 p.m. an interview was held with business office worker Employee E20. Employee E20 did confirm that he was a witness to Resident R148 verbally attacking Resident R2. He stated I hear some loud noise, but didn't think anything of it at first then I heard R2 yelling. I came out and Resident R148 was cursing at Resident R2. When Employee E20 was asked if he could remember anything specific he stated, yes, Don't let me catch you down here again. When asked if he told anyone Employee E20 stated yes Employee E18. 28 PA. Code 201.14(a) Responsibility of licensee 28 PA. Code 201.18(b)(1) Management 28 PA. Code 211.10(c)(d) Resident care policies 28 PA. Code 211.12(d)(1)(5) Nursing services		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395330	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/03/2025
NAME OF PROVIDER OR SUPPLIER Independence Rehab and Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 600 W Cheltenham Avenue Philadelphia, PA 19126	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0839 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ staff that are licensed, certified, or registered in accordance with state laws. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical record, review of facility documents, job descriptions and interview with staff it was determined that the facility failed to ensure that a qualified staff performs a wound assessment for one of nine residents reviewed (Resident R13)Review facility job description for licensed nursing staff revealed Job summary qualifications responsibilities duties and tasks of a charged nurse. Further review of the facility's job description for a charged nurse revealed that there was no specific job description for a registered nurse and there was no specific job description for a licensed practical nurse.Review of Resident R13's clinical record revealed that Resident R13 was admitted to the facility on [DATE], with diagnoses of but not limited to Hypertension, Rheumatoid Arthritis, HypothyroidismReview of Resident R13's skin assessment dated [DATE], revealed that resident was at risk for skin breakdown with a score of 17.Further section G (Additional observation) of Resident R13's skin assessment revealed DTI (deep tissue injury) to left heel and right buttocks skin alteration. Further, skin assessment dated [DATE], was performed by a licensed practical nurse. Further review of Resident R13's clinical record revealed no documented evidence that a wound assessment was performed by a Registered Nurse or other licensed medical professionals who are allowed by to perform an assessment, upon identification of the DTI on the left heel and skin alteration of right buttocks. Interview with Employee E2 conducted on September 19, 2025, confirmed that Licensed Practical N'urses are not allowed to assess and that only a Registered Nurse can perform an assessment. Further Employee E 2 revealed that she will conduct an inservice to all nurses related to their functions. 28 Pa. Code 201.1 Responsibility of licensee		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on observations of the physical environment of the building on the first floor, reviews of the pest control operators reports and interviews with staff, it was determined that the facility was not maintaining an effective pest control program. Findings include: Observations of the physical environment of the facility revealed that the food and nutrition department was located on the first floor (ground floor) of the building. Further observations revealed that the trash and refuse area for the entire building was located through the double doorway in the back hallway that was adjacent to the main kitchen and dry food storage area. Observations of the double doors leading directly outside the building and into a driveway where the trash and garbage disposal system (dumpster unit) was held, revealed that these doors did not seal upon closing. A two-inch void was visible between the doors. The gap provided easy access for common household pests and rodents (mice, flies, roaches) to enter the building on the first floor. A review of the pest control operator's reports for September 3, 2025, revealed that the main kitchen and food storage area was being treated for mice activity. The pest control operator identified areas of the building that structural voids needed to be sealed. A review of the pest control operator's reports for August 4, 2025, revealed that the pest control operator treated the kitchen for common household pests (roaches and flies). The pest control operator advised the kitchen staff to practice deep cleaning and floor power washing throughout the kitchen to maintain a clean and sanitary food service department. A review of the pest control operator's report dated July 28, 2025, revealed that the dumpster area was treated for fly infestation. The pest control operator indicated that there was food debris and liquid food spillage surrounding the dumpster unit that was attracting the pests to the trash and refuse area of the facility. A review of the pest control operator's report dated July 28, 2025, revealed that the kitchen was treated for common household pest activity (roaches and flies). The pest control operator said that the main kitchen flooring needed to be power washed and grease spills and food debris needed to be removed from the hot food preparation area to maintain the main kitchen in a clean and sanitary manner and prevent the feeding and breeding of pests and rodents. 28 PA. Code 201.14(a) Responsibility of licensee 28 PA. Code 201.18(b)(1)(3)(e)(1)(2.1)(3) Management		